

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

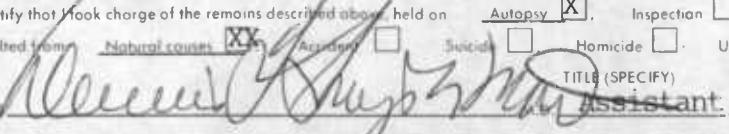
1-~~87~~ FOR  
STATE  
REGISTRAR

REG. NO. 0527

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR
Franklin D. AMICK						2	20	87	6A
3a SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
Male	White	Nov. 13, 1932	54 yrs.			2	20	87	2d HOUR 820A
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett		
West Virginia		USA							
10. OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DOA) Garrett Co Mem. H hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
					Sales Representative		Tire Company		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	MD			
Va.	Henrico	Richmond			11411 Brendonridge Ct. 23233				
FATHER'S NAME									
FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		LAST				
Alex	Owen	Amick	Lucy		Strickland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			ADDRESS			
(IF YES, GIVE WAR OR DATES) Yes Korean			235-44-9731			Jeff D. Amick, Richmond, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Arteriosclerotic occlusion, left anterior</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden									
DUE TO, OR AS A CONSEQUENCE OF <u>descending coronary artery</u>									
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>									
(b) <u>Coronary artery heart disease</u> years									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D. DATE SIGNED 2-20-1987 EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D. 107 S. 2nd. St., Oakland, Maryland ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL Westhampton Mem. Park			23d. LOCATION CITY OR TOWN		COUNTY	
burial		2/23/87				Richmond, Henrico, Virginia		STATE	
24. FUNERAL DIRECTOR NAME Bradley A. Stewart ADDRESS Oakland, Maryland 21550 25a. DATE REC'D. BY REGISTRAR FEB 25 1987 25b. REGISTRAR'S SIGNATURE <i>J. A. Deaderick, Registrar</i>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05121				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
John			David			Boring						<input checked="" type="checkbox"/>				2 14 19 87 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 9:02A M		
Male	White	11 18 31	55 yrs							2 14 19 87						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			Garrett County,			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett County Memorial Hospital										Dealer Acct Mgr.			Car Credit	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md.		Carroll		Hampstead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4008 Dana Ct. 21074							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Thaddeus				Boring		Neva						Pickett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS									
yes		Korean		216-30-7053			Mrs. Carole Boring, Hampstead, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
{ (b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.														TITLE (SPECIFY) MEDICAL EXAMINER		
ADDRESS 111 Penn St. Balto. MD.														DATE SIGNED 2/15/87		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2-17-87		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery			23d. LOCATION CITY OR TOWN Hampstead			23e. COUNTY Carroll	23f. STATE Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS Elaine Funeral Home, Hampstead, Md.			25a. DATE REC'D. BY REGISTRAR FEB 18 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Lundell								
BP																
DHMH - 17 (VR A15 ME (5))																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

044522 FEB 1987

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8705122

1. DECEASED NAME (TYPE OR PRINT)			FIRST Goldie	MIDDLE Mae	LAST Casteel	2a. DATE OF DEATH February 10 1987	MONTH February	DAY 10	YEAR 1987	2b. HOUR 3:15AM	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH Sept	DAY 5	YEAR 1907	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.				
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.		12b. KIND OF BUSINESS OR INDUSTRY Domestic				
13a. STATE W.Va.			13b. COUNTY Preston	13c. CITY OR TOWN Terra Alta	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 419 West State St.				
14. FATHER'S NAME FIRST Arthur			MIDDLE	LAST Miller	15. MOTHER'S MAIDEN NAME FIRST Nora		MIDDLE Bell	LAST Rekart	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 236-44-7202		17. INFORMANT Ruby Frantz		18. ADDRESS 415 W. State St. Terra Alta, WV 26764				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>malnutrition secondary to multiple bowel resections for necrotic vascular occlusion</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (his hospital) attended the deceased from <i>4/9 1987</i> to <i>2/10 1987</i> that (1) (we) last saw the deceased alive on <i>2/9 1987</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Donald R. Richter</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/10/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. Richter		22e. ADDRESS 311 N. Fourth St.		22f. ADDRESS Oakland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/87		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION CITY OR TOWN Terra Alta		COUNTY Preston	STATE WVa		
24. FUNERAL DIRECTOR NAME <i>Arthur H. Wright</i>		ADDRESS Terra Alta, WV 26764		25a. DATE REC'D. BY REGISTRAR <i>FEB 17 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>					



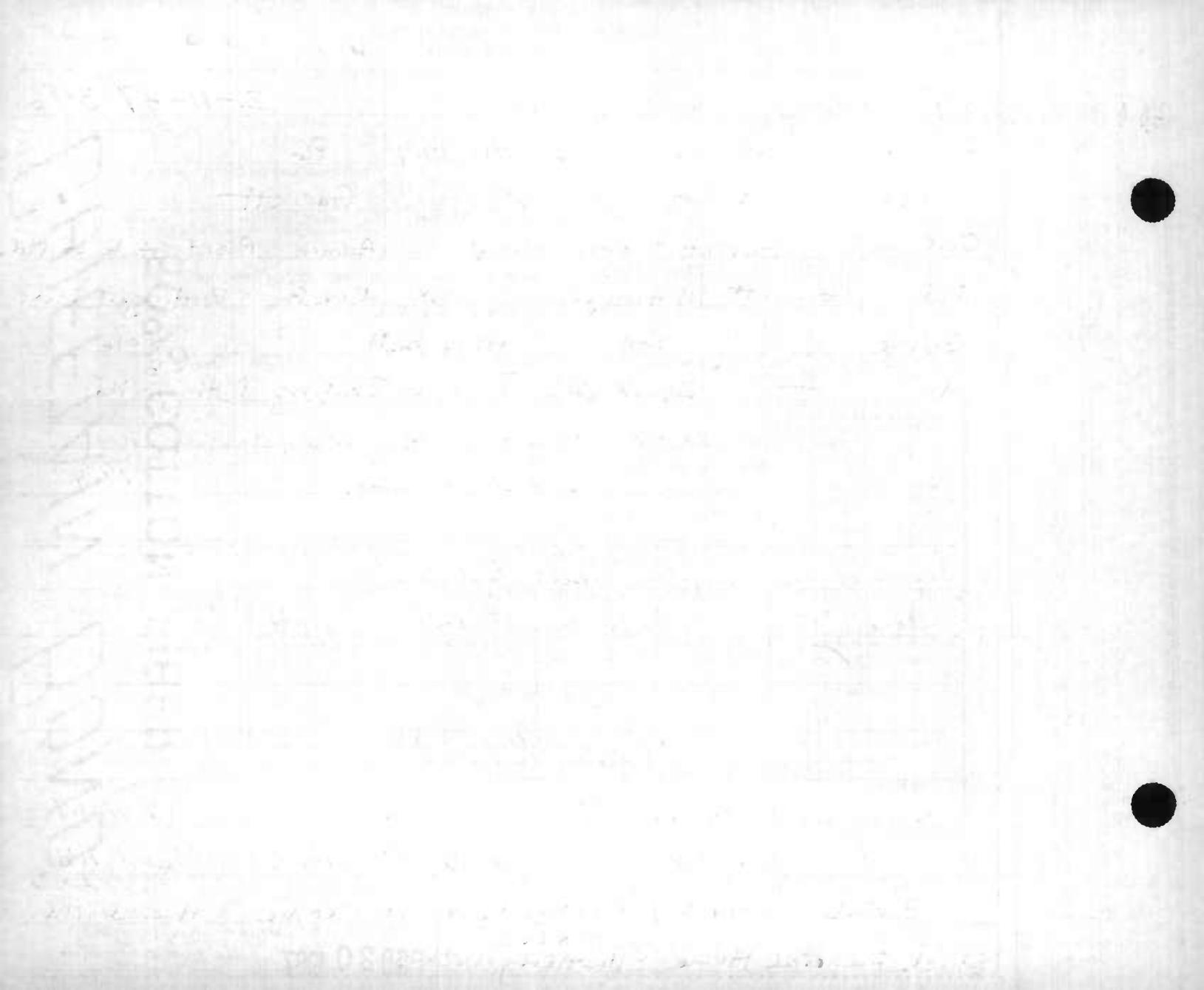
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified by one:

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 / 05 123											
										REG. NO.											
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR									
22 87			Thelma Lee Collins						2-11-87			345 pm									
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Mem. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin			12b. KIND OF BUSINESS OR INDUSTRY Assist Slack of Md.	
13a. STATE Md.			13b. COUNTY Garrett			13c. CITY OR TOWN Bittinger			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 8 21522 Bittinger, Md.									
14. FATHER'S NAME FIRST MIDDLE LAST George Lee			15. MOTHER'S MAIDEN NAME Annabell Cole			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 246-28-6702			17. INFORMANT Jane L. Sealing			ADDRESS Box 8 Bittinger, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute increase intra cranial pressure</u> hours										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <u>inoperable brain tumor</u> 1984											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>inoperable brain tumor</u>										(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>hiatus hernia, congestive heart failure</u>																					
19a. DATE OF OPERATION April '85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ventricular Shunt			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Aug 19 86			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 86 to 211 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 2-11-87											
22c. SIGNATURE Margaret A. Kaiser MD										22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KAISER										22f. ADDRESS 311 N 4th Suite 3 Oakland, Md. 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-14-87			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN ElKridge COUNTY Howard STATE Md.												
24. FUNERAL DIRECTOR NAME Slack Funeral Home Ellicott City, Md. 21042										25a. DATE REC'D. BY REGISTRAR FEB 20 1987											
ADDRESS Box 268										25b. REGISTRAR'S SIGNATURE Julia Sieden-Lindner											



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be summoned to inspect the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8705124	REG. NO.							
1 - STATE REGISTRAR		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	February	15	1987	3:00 a.m.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		January 22, 1916			71 yrs.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		Garrett MD.				
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Friendsville		908 Second Avenue			Homemaker			Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		21531			
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		908 Second Avenue, P.O. Box 203							
14. FATHER'S NAME FIRST John		MIDDLE H.		LAST Sines		15. MOTHER'S MAIDEN NAME Amanda		MIDDLE ---		LAST VanSickle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		16c. ADDRESS P.O. Box 203		17. INFORMANT Mrs. <del>XX</del> Eleanor Cole		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>minutes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>Atherosclerotic Vascular Disease</i> years (c) <i>Adult Onset Diabetes Mellitus</i> years					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>minutes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>Atherosclerotic Vascular Disease</i> years (c) <i>Adult Onset Diabetes Mellitus</i> years					19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1978 to 1987, that (I) (we) last saw the deceased alive on 2-11-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>George B. Stoltzfus</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-18-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus		22e. ADDRESS Friendsville, MD 21531											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/87		23c. NAME OF CEMETERY OR CREMATORIUM Sand Spring Cemetery			23d. LOCATION CITY OR TOWN Friendsville, Garrett, MD						
24. FUNERAL DIRECTOR <i>S. Lynn Newman</i>		ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR FEB 24 1987				25b. REGISTRAR'S SIGNATURE <i>John L. Johnson</i>					
BP _____													
DHMH - 16 60M 7/84 (VRA 15, 4)													

4834 500 1984

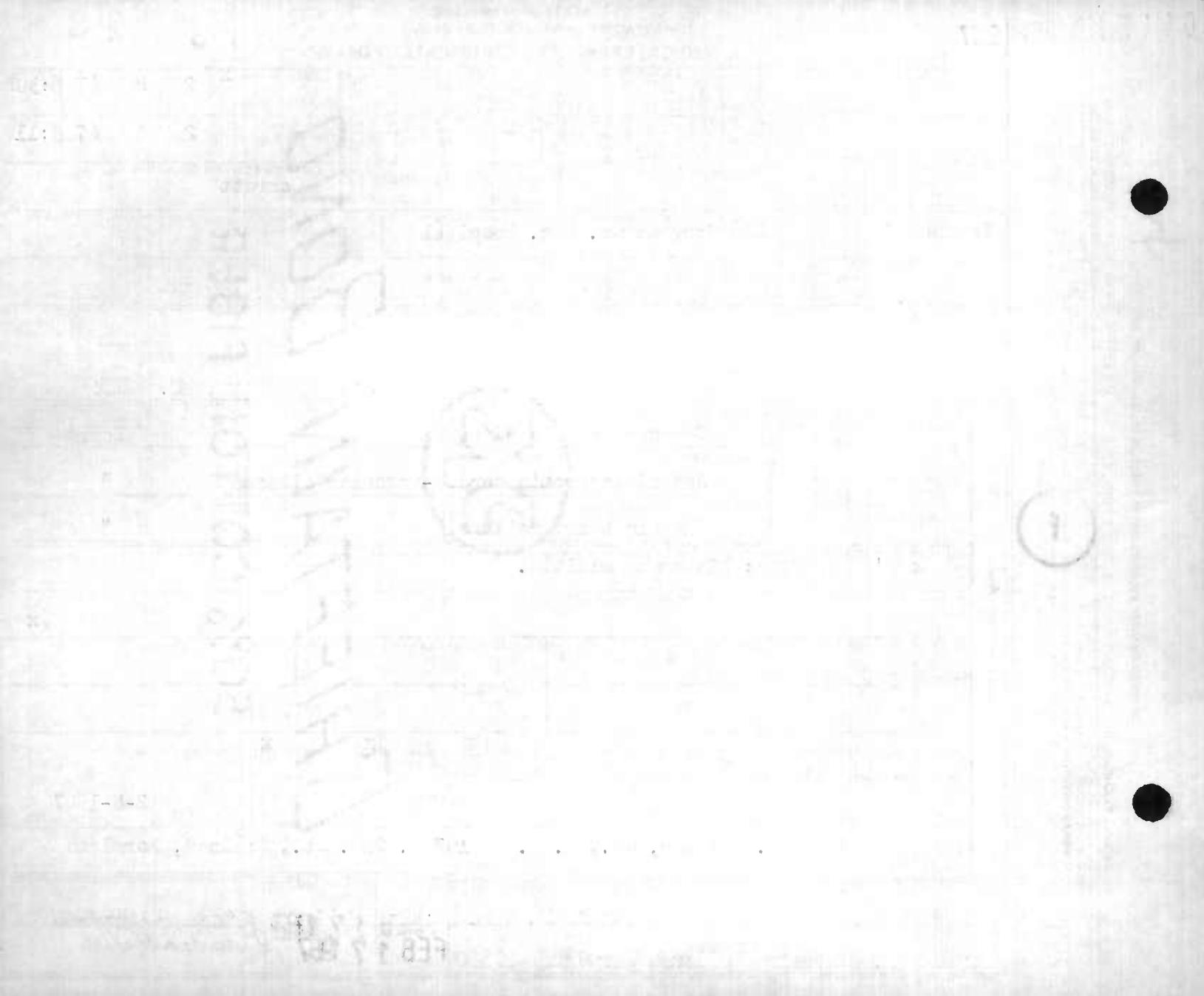
044519 FEB

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMUM 1. RETAIN FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05125  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF ESTI- DEATH MATED				21. MONTH DAY	22. DAY	23. HOUR
William			Hugh		FAULKNER	<input type="checkbox"/>				2	8	87
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	26. DATE PRONOUNCED DEAD				27. MONTH 2	28. DAY	29. YEAR
Male	White	June 28, 1928	58 yrs			<input type="checkbox"/>				8	8	87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett				MD		
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DOA) Garrett Co. Mem. Hospital			12a. USUAL OCCUPATION   TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Route #4, Box 58		21550				
14. FATHER'S NAME FIRST Joe		MIDDLE -----	LAST Faulkner	15. MOTHER'S MAIDEN NAME FIRST Vivian				MIDDLE Delores	LAST Wilt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Joe Faulkner, Deer Park, Md.				21550				
No		216-66-0712										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Coronary artery disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												
(b) Arteriosclerotic cardio-vascular disease //												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Chronic heart failure //												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Down's Syndrome; Diabetes mellitus.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		TITLE DEPUTY M.D.				MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		James H. Feaster, Jr., M. D.				ADDRESS 107 S. 2nd. St., Oakland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial 2/11/87		23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gardens, Oakland, Garrett, Maryland		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS Bradley A. Stewart Oakland, Maryland 21550		25. DATE DECEASED BY MEDICAL EXAMINER'S SIGNATURE FEB 17 1987		REINSTATEMENT OF DEATH CERTIFICATE						
BP		DHMH - 17 (VR A15 ME (5))										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then placed in the carbon papers, Pages 1 and 2 should be detached for use on the burial/cremation permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury or condition, in any event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 05129											
1. DECEASED NAME (TYPE OR PRINT)			FIRST: Emma			MIDDLE: Louise			LAST: Glotfelty		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH: 62 DAY: 18 YEAR: 1903			6. AGE (IN YEARS LAST BIRTHDAY) 83 YES		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett, MD.		
10. CITY OR TOWN OF DEATH Grantsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Garrett			13c. CITY OR TOWN Accident			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST: Samuel			MIDDLE: ---			LAST: Brenneman			15. MOTHER'S MAIDEN NAME FIRST: Sarah		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ---			17. INFORMANT Dale O. Glotfelty			18. STREET ADDRESS Route 1, Box 94; 21520		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinsons Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Days</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Organic Brain syndrome</u>											
19a. DATE OF OPERATION 9/9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that (I) (the hospital) attended the deceased from <u>1-16-87</u> 19 <u>87</u> to <u>1-23-87</u> 19 <u>87</u> , that (II) <u>last</u> saw the deceased alive on <u>2-4-1987</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> <u>not</u> view the body after death.											
22b. SIGNATURE <u>George Stoltzfus, M.D.</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2-25-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Stoltzfus, M.D.			22e. ADDRESS Maple Street, Friendsville, MD 21531								
23a. BURIAL, CREMATION, REMOVAL (S) Burial			23b. DATE 2/28/87			23c. NAME OF CEMETERY OR CREMATORIAL Bittinger Cemetery			23d. LOCATION CITY OR TOWN Bittinger, Garrett, MD		
24. FUNERAL DIRECTOR <u>Suzanne Brenneman</u>			ADDRESS Grantsville, Maryland			25a. DATE REC'D. BY REGISTRAR FEB 27 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Dendron-Randall</u>		

1983-188

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05127  
REG. NO.

FOR  
1-  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)			FIRST Larry	MIDDLE Keith	LAST James Sr.	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH 2	DAY 28	YEAR 87	2b. HOUR 12:15 PM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH Aug	YEAR 1942	6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD MONTH 2	DAY 28	YEAR 87	2d. HOUR 12:55 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett				
10. CITY OR TOWN OF DEATH Mt. Lake Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 H. St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Const.				
13a. STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Mt. Lake Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 502 H. St.			21550			
14. FATHER'S NAME FIRST Antonio			MIDDLE	LAST James	15. MOTHER'S MAIDEN NAME FIRST Tina			MIDDLE	LAST Knotts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Viet Nam 213 40 3634			17. INFORMANT Larry K. James Jr. Mt. Lake Park, Md.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound to the head - 30-30 calibre rifle DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Herbert H. Leighton</i> TITLE (SPECIFY) M.D. Act. Assist. MEDICAL EXAMINER												
DATE SIGNED 28 Feb 87												
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME Herbert H. Leighton, M.D.			ADDRESS Oak @ 5th Sts., Oakland, MD 21550							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 3-1-87		23c. NAME OF CEMETERY OR CREMATORIAL IOOF Cemetery		23d. LOCATION CITY OR TOWN Elk Garden Mineral W. Va		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS David A. Burdock Kitzmiller, Md. 21538			25a. DATE REC'D. BY REGISTRAR MAR 04 1987		25b. REGISTRAR'S SIGNATURE <i>John R. Burdock</i>					

3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 05124											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Betty			MIDDLE Jean			LAST HARDESTY		
2a. DATE OF DEATH MONTH DAY YEAR			February 10, 1987			2b. HOUR			350 A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.		
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #3, Box 37-B 21550			
14. FATHER'S NAME FIRST Frederick			MIDDLE Kenneth			LAST Paugh			15. MOTHER'S MAIDEN NAME FIRST Dora		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-82-9581			17. INFORMANT Mr. Stanley M. Hardesty, See #13 above			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest			DUE TO, OR AS A CONSEQUENCE OF (b) severe chronic obstructive pulmonary disease Years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) attended the deceased from 2/10/87 to 2/10/87, that (I) last saw the deceased alive on 2/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check (f).)											
22b. SIGNATURE Donald L. Miller			DEGREE DO			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/10/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. P. Daniel Miller, DO			22e. ADDRESS 311 N. Fourth St., Oakland, Md. 21550								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 2/12/87			23c. NAME OF CEMETERY OR CREMATORIAL Moon Cemetery			23d. LOCATION CITY OR TOWN Deer Park, Garrett, Maryland COUNTY STATE		
24. FUNERAL DIRECTOR Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR FEB 17 1987			25b. REGISTRAR'S SIGNATURE Julie L. Miller		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

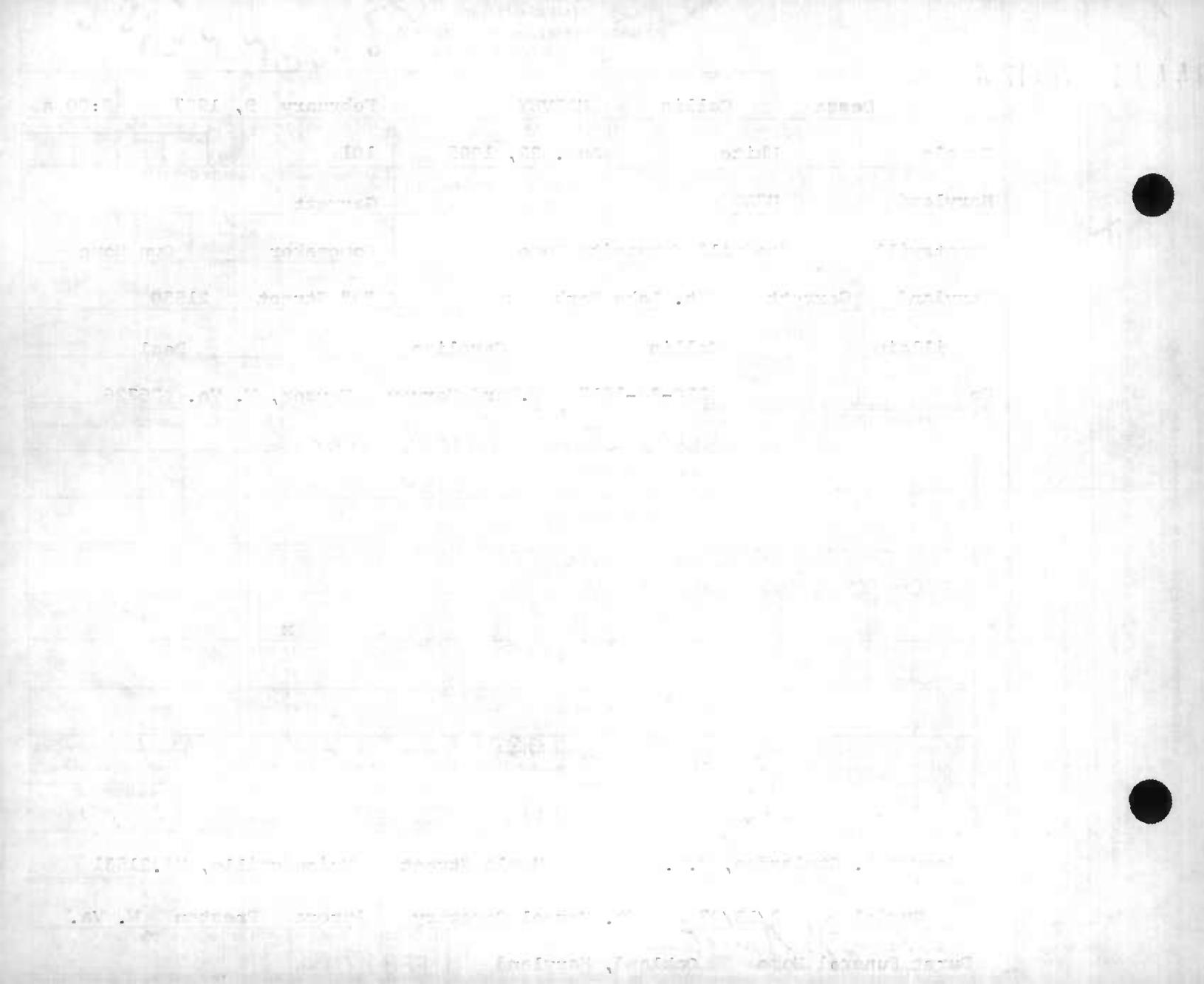
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05130						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Dessa			Callis				HARVEY			February		9, 1987			8:00 am	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.			7. IF UNDER 1 YEAR MONTHS		# UNDER 24 HRS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
10. CITY OR TOWN OF DEATH Grantsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Garrett		13d. CITY OR TOWN Mt. Lake Park		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS "D" Street 21550		
14. FATHER'S NAME FIRST Willaim			MIDDLE Callis		15. MOTHER'S MAIDEN NAME FIRST Caroline			MIDDLE		LAST Deal						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO No 220-34-1517		17. INFORMANT W. Ward Harvey			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS Keyser, W. Va. 26726						
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>multisystem failure of age</u>																
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Gastrointestinal bleed.</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>1980</u> 19 to <u>2-9-1987</u> , that (1) (we) last saw the deceased alive on <u>2-4-1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>George B. Stoltzfus</u>			22c. DEGREE <u>M.D.</u>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>2-11-87</u>									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus, M.D.			22g. ADDRESS Maple Street		22h. ADDRESS Friendsville, Md. 21531											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/12/87		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery			23d. LOCATION CITY OR TOWN Aurora		COUNTY Preston		STATE W. Va.				
24. FUNERAL DIRECTOR NAME <u>Robert M. Stoltzfus</u>			ADDRESS Durst Funeral Home		25a. DATE REC'D. BY REGISTRAR FEB 17 1987			25b. REGISTRAR'S SIGNATURE <u>Robert M. Stoltzfus</u>								

BP \_\_\_\_\_

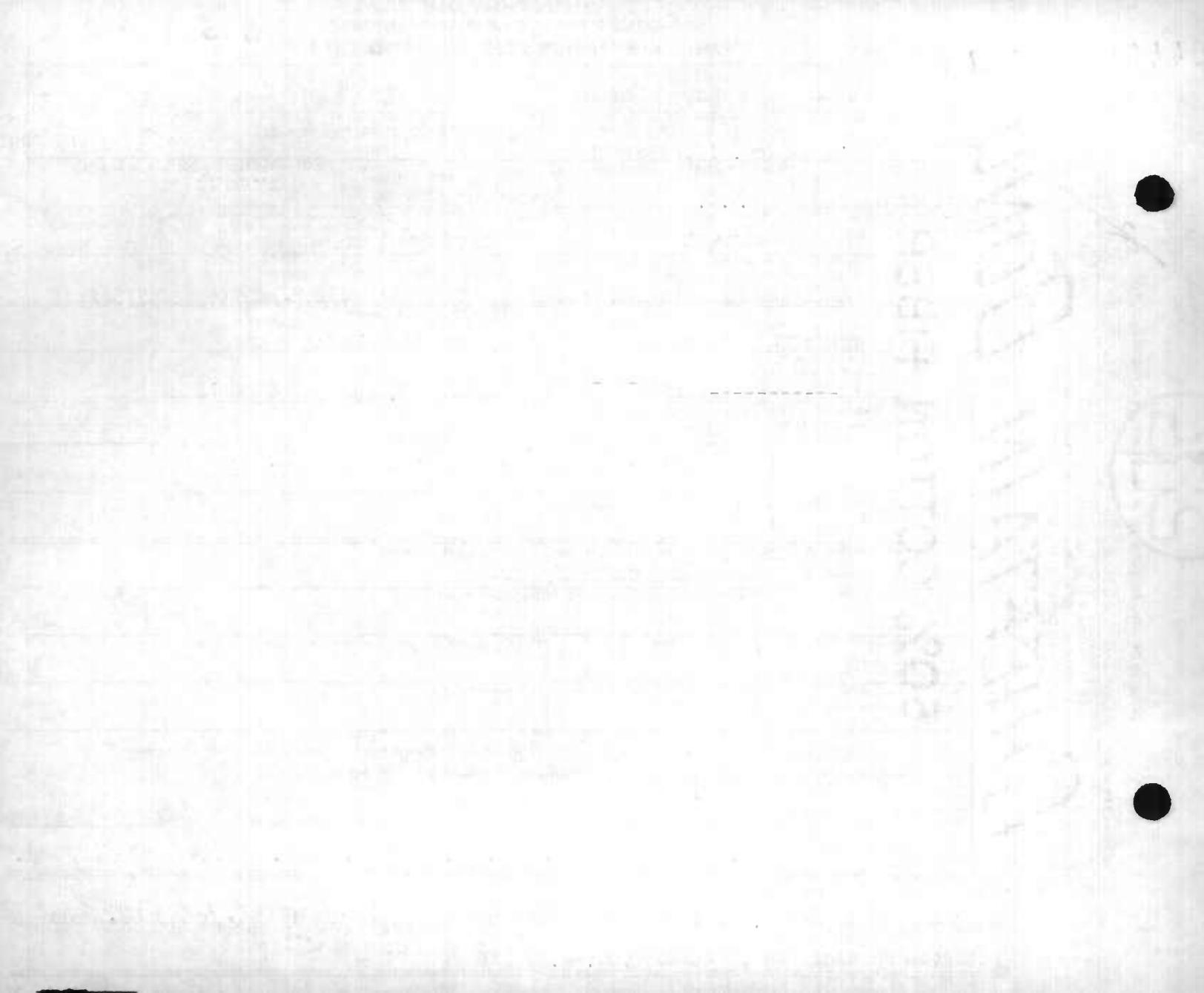
DHMH-16 25M  
(VRA 15, 4) 1/79



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, RETAIN PAGE 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05131							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	2b. MONTH	DAY	YEAR	2b. HOUR			
Lillie			May			Ledlow						<input checked="" type="checkbox"/>	2	16	19	87	P 1220		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
Female		Cau.		Nov. 18, 1895		91 yrs.						2c. DATE PRONOUNCED DEAD		2		16 87		1245 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.										<input checked="" type="checkbox"/>		<input type="checkbox"/>		Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Oakland		Dennett Road Manor Nursing Home										Homemaker				Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Allegany		Westernport		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		430 Vine Street 21562									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE											
James		Randolph		Hines		Sarah		Melissa		Shank									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		347-01-1744		Louise H. Lease		same 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
Chronic cardiac failure																			
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardio-vascular disease												"							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
COPD; Chronic brain syndrome																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
			P.M. 19																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>												TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D. 107 S. 2nd. St., Oakland, Md.												DATE SIGNED 2-16-1987							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Burial			Feb. 18, 1987			Philos Cemetery			Westernport			Allegany		Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Fredlock Funeral Home, Piedmont, W.Va. 26750									Feb. 18, 1987										
07/84 25M																			
BP																			
DHMH - 17 (VR AT5 ME (5))																			



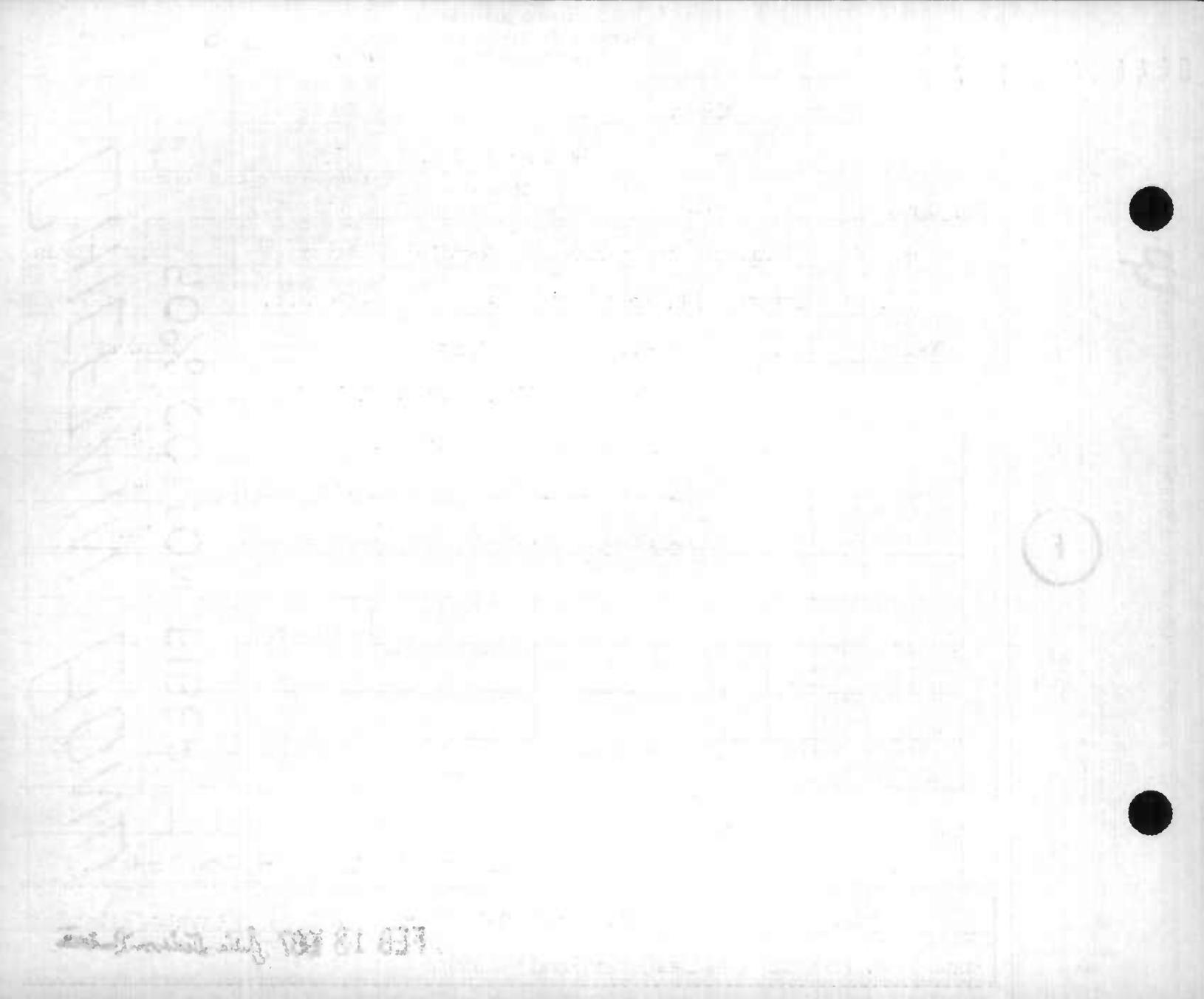
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then detach remove carbon paper, pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any evidence of foul play or other unusual event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05152				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			January 29, 1987							1055P M	
Oliver Albert LEWIS														
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
						January 5, 1912			75		MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			YRS		
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker			12b. KIND OF BUSINESS OR INDUSTRY County Roads			MD.		
13a. STATE Md.			13b. COUNTY Garrett			13c. CITY OR TOWN Mt. Lake Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 808 N St. 21550			
14. FATHER'S NAME FIRST Emory MIDDLE E. LAST Lewis						15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE ----- LAST Hardesty								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-09-7666			17. INFORMANT Mrs. Juanita H. Lewis, See #13 above						ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			respiratory Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) Pseudomonas aeruginosa with abscess									Weeks		
			DUE TO, OR AS A CONSEQUENCE OF (c) End Stage Coal Workers Pneumoconiosis									Years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from saw the deceased alive on above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.			1/29/87 19 87			19, 1987, to 1/29/1987, 1987, that (I) <input checked="" type="checkbox"/> last								
22b. SIGNATURE Dr. Roger Lewis, MD						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/29/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Roger Lewis, MD						22e. ADDRESS Cranberry Clinic, Terra Alta, West Va.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 2/1/87			23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.			23d. LOCATION CITY OR TOWN Oakland, Garrett, Maryland			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Bradley A. Stewart ADDRESS Oakland, Maryland 21550						FEB 13 1987 Julie Dawson, R.R. 1								

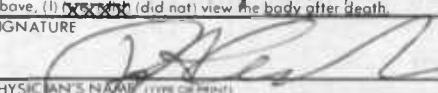


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the liquidation permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Name 21 is marked on line 20, ~~any~~ injury, or other traumatic event, the medical examiner must be notified.)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0515			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Rosalind May McCOLLOUGH						January 23, 1987			500 P M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		April 17, 1914			72			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA					Garrett			MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
McHenry		Star Route #2, Box 45-A								Housewife		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Md.		Garrett		Mt. Lake Park			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14 Paull Street 21550				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Frank Henry Clary		Frances Myrtle Beham											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		213-12-2906		Mrs. Mary E. DeWitt, See #'s 9, 10, 11 above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
COMA													
DUE TO, OR AS A CONSEQUENCE OF (b) GLIOBLASTOMA MULTIFORME													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>1985</u> 19 to <u>Jan 23</u> 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Jan 14</u> 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.													
22b. SIGNATURE 										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Goralski, MD										22e. ADDRESS 311 North Fourth St., Oakland, Md. 21550			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION CITY OR TOWN COUNTY STATE									
burial		1/26/87		Deer Park Cemetery Deer Park Garrett, Maryland									
24. FUNERAL DIRECTOR NAME Bradley A. Stewart ADDRESS Oakland, Maryland 21550										25. REGISTERED STATE FEB 13 1987			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05134 REG. NO.		
1 - STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2-28 19 87							2b. HOUR MONTH DAY YEAR		
DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST					
David			MARK		MCLELLAN							
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. HOUR MONTH DAY YEAR	
Male	White	July 15, 1964	22 yrs.		MONTHS	DAYS	HOURS	MIN	2-28 19 87	2d. HOUR 6:45 p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania			USA						Garrett County, MD.			
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Deer Park			Boathouse - Deep Creek Lake Rt. 4						Student		99999	
13. STATE Pennsylvania			13b. COUNTY Allegheny			13c. CITY OR TOWN Upper St Clair		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1529 Jenkins Dr. 15241		
14. FATHER'S NAME FIRST George			MIDDLE Edward			LAST McLellan		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Anne		LAST Facemire
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT G. Edward McLellan - same as 13			ADDRESS			
NO			209-48-8305									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Shotgun Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 3:15 P.M. 2-28 19 87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) boathouse			21f. LOCATION STREET Deep Creek Lake, Rt. 4, Deer Park, Garrett Co., Maryland			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER										DATE SIGNED 3-1-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/4/87			23c. NAME OF CEMETERY OR CREMATORY Penn Cremation Service			23d. LOCATION CITY OR TOWN Pittsburgh Allegheny, Pa.			
24. FUNERAL DIRECTOR NAME Robert M. Durst			ADDRESS Durst Funeral Home - Oakland, Md. 21550			25a. DATE REC'D. BY REGISTRAR MAR 04 1987			25b. REGISTRAR'S SIGNATURE			
(VR A15-ME (5))												

1

- 4646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place the original carbon papers, Pages 1 and 2, in the envelope, and mail with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be attached.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05135	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Donald Glenn Miller, Sr.						29 87			120 P M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		September 7, 1928			58				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett		10. CITY OR TOWN OF DEATH Oakland		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 69 21550		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME Iva Naomi Burns									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220-26-9362			17. INFORMANT Mrs. Iva N. Miller, Oakland, Md. 21550						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Asthma s/p m/s</i>										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (c)										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Dm</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 19 87</i> to <i>Feb 9 87</i> , that (I) (we) last saw the deceased alive on <i>Feb 9 87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>T. Johnson</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/9/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T. Johnson</i>			22e. ADDRESS 311 N. Fourth St., Oakland, MD 21550								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 2/13/87			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Thomas, Tucker, West Va. COUNTY STATE		
24. FUNERAL DIRECTOR Bradley A. Stewart			25a. ADDRESS Oakland, Maryland 21550			25b. DATE REC'D. BY REGISTRAR FEB 17 1987			25b. REGISTRAR'S SIGNATURE <i>John Anderson</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it can and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate to the physician. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

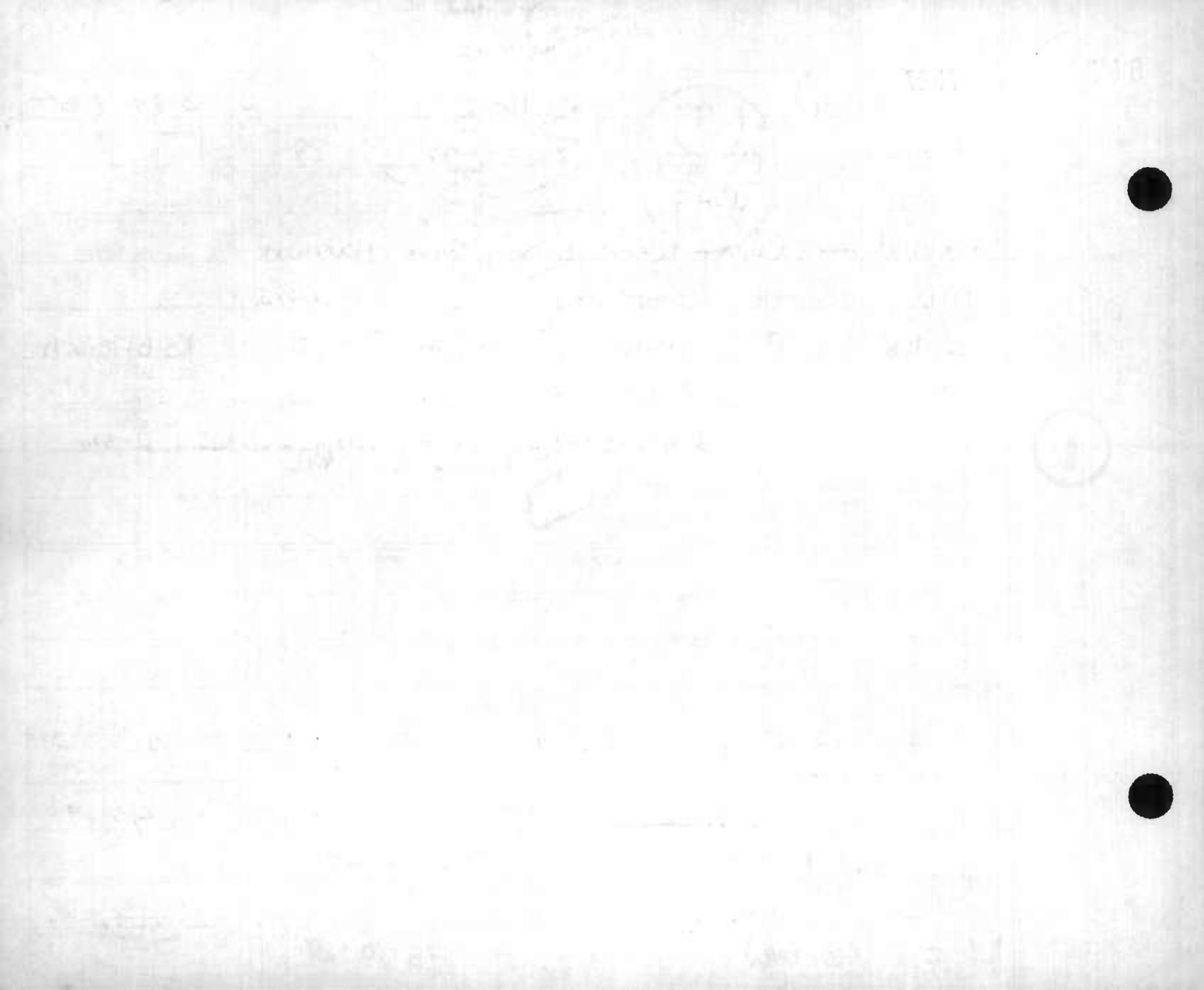
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other circumstances, the medical examiner should be informed.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 05150

1. DECEASED NAME (TYPE OR PRINT)			FIRST Edith	MIDDLE ---	LAST Miller	2a. DATE OF DEATH MONTH YEAR 2 - 3 - 87	DAY YEAR 8:30 PM	2b. HOUR M	
3. SEX Female			4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 8 9 28 - 97	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY MD.			7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett, MD.				
10. CITY OR TOWN OF DEATH Oakland, PA.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppert Weeks Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework			
13a. STATE MD.			13b. COUNTY Garrett	13c. CITY OR TOWN Grantsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Box 285, 21536	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
14. FATHER'S NAME FIRST John			MIDDLE P	LAST Miller	15. MOTHER'S MAIDEN NAME Lavinnia	LAST O. KolbFleisch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-30-8602A			17. INFORMANT ADDRESS Route 2, Box 105 Warren D. Miller Keyser, WV 26726			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary			DETO, OR AS A CONSEQUENCE OF Arrest - etiology uncertain Probably Acute MI			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost			(b)						
(c)			DETO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from 9 19 86 to 2/3 19 87, that (I) (we) last saw the deceased alive on 2/1 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Karl E. Schulz		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/3/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karl E. Schulz		22e. ADDRESS Oakland, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 6, 87		23c. NAME OF CEMETERY OR CREMATORIAL Springs Cemetery		23d. LOCATION CITY OR TOWN Springs, COUNTY Somerset, STATE PA.			
24. FUNERAL DIRECTOR D. Lynn Newman		ADDRESS Grantsville, MD			25a. DATE REC'D. BY REGISTRAR FEB 09 1987				



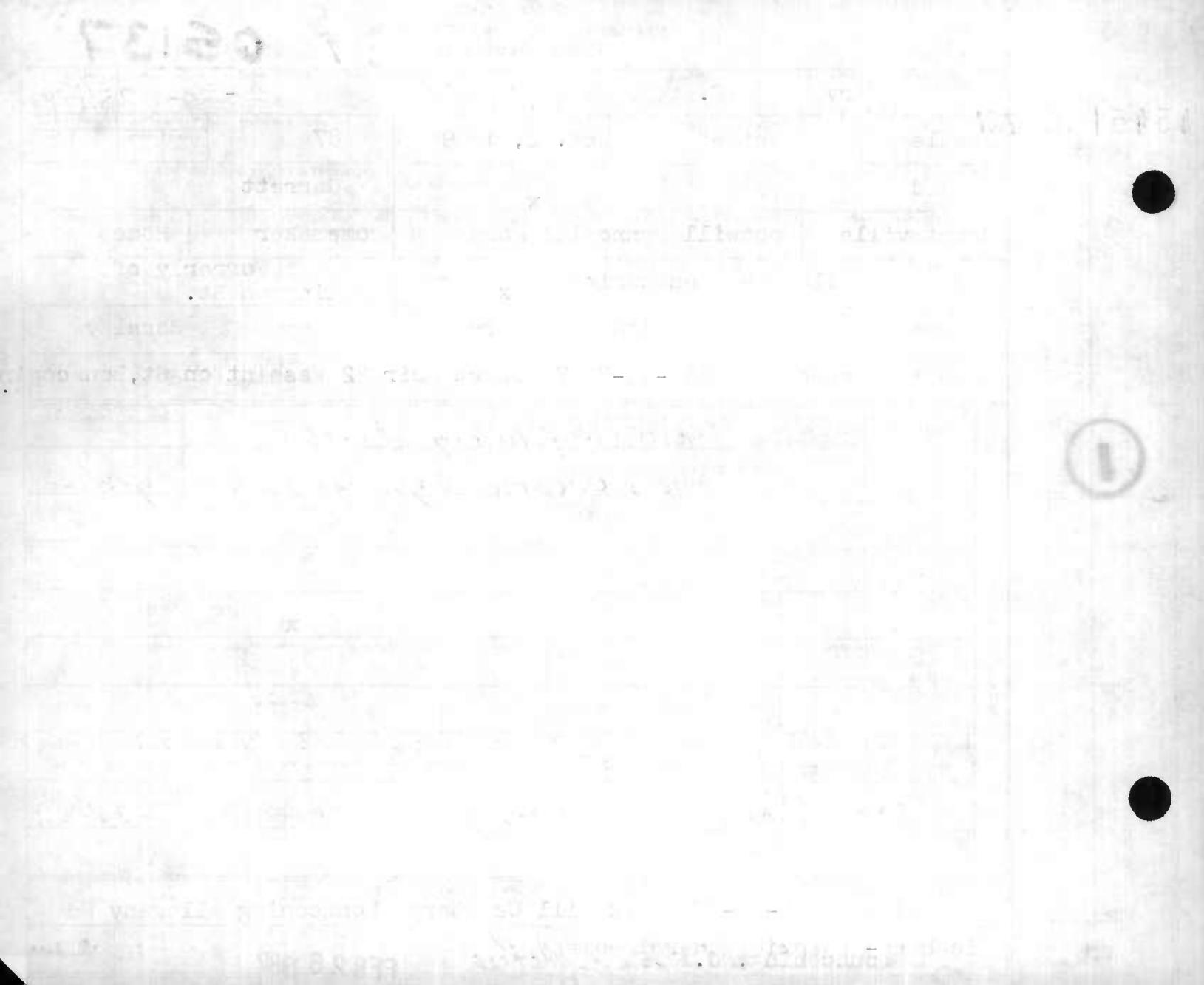
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Please sign and complete this certificate within 24 hours. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remit payment to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked off, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 REG. NO. 05137	
1 DECEASED NAME (TYPE OR PRINT)		FIRST Mary	MIDDLE F.	LAST Muir	2a DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b HOUR 5:45 P.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH Oct. 2, 1899	6 AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Garrett		IF UNDER 24 YRS HOURS MIN		
10 CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Goodwill Mennonite Home		12a USUAL OCCUPATION (IF WORKING, INDICATE WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY HOME			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md		13b COUNTY Allegany	13c TOWN Lonaconing	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS Formerly of Washington St. 21539				
14 FATHER'S NAME Adam		MIDDLE Smith	15 MOTHER'S MAIDEN NAME Mary	16 ADDRESS Robert Muir 22 Washington St, Lonaconing Md.		Barelay			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b SOCIAL SECURITY NO. 219-14-7287		17 INFORMANT Robert Muir		ADDRESS 22 Washington St, Lonaconing Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cold/Respiratory Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Vascular Disease</u> Years									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) AORTIC Stenosis									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a I certify that (I) (this hospital) attended the deceased from 2-9-81 to 2-20-81, that (I) (we) last saw the deceased alive on 2-4-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Ron Atkey</u>		DEGREE Mr.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-22-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ron Atkey</u>		22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2-26-87		23c NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION CITY OR TOWN Lonaconing			
24. FUNERAL DIRECTOR Eichhorn-McKenzie Funeral Home Lonaconing, Md.		25a DATE REC'D. BY REGISTRAR FEB 26 1987		25b. REGISTRAR'S SIGNATURE <u>Jane E. McNeil</u>		COUNTY Allegany STATE Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 05138

1. DECEASED NAME (TYPE OR PRINT)				FIRST Isaac	MIDDLE Richard	LAST Peters	2a DATE OF DEATH MONTH DAY YEAR 7 2 1920	2b HOUR 2/6/87 3 <sup>rd</sup> AM
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 2 1920		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett County		MD.
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b KIND OF BUSINESS OR INDUSTRY Coal		
13a STATE WVa		13c CITY OR TOWN Terra Alta		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 514½ Shaffer St. 26764		99999
14a FATHER'S NAME Isaac		14c MOTHER'S MAIDEN NAME Charlotte		15 MOTHER'S MAIDEN NAME Charlotte		16a SOCIAL SECURITY NO. 236-16-6991		LAST Fortney
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17. INFORMANT Helen V. Peters		17. INFORMANT Helen V. Peters		18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 514½ Shaffer St. Terra Alta, WV26764		
18b CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		18c DUE TO, OR AS A CONSEQUENCE OF (b) Probable Myocardial Infarction		18d DUE TO, OR AS A CONSEQUENCE OF (c) Long standing hypertension				
19a MEDICAL CERTIFICATION DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>2/6/87</u> 19 <u>87</u> to <u>2/6/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Mark Domenick</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2/6/87		
22e. ADDRESS Mark Domenick		22f. ADDRESS Oakland, Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2/9/87		23c NAME OF CEMETERY OR CREMATORIAL Shay Cemetery		23d LOCATION CITY OR TOWN Tunnelton		COUNTY STATE Preston WVa.
24. FUNERAL DIRECTOR NAME Arthur H. Wright		25a. DATE REC'D. BY REGISTRAR ADDRESS Terra Alta, WV 26764		25b. REGISTRAR'S SIGNATURE Julia Davidson-Norrell		FEB 10 1987		

999999  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return to physician. Pages 1 and 2 should be held with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



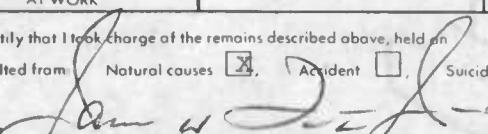
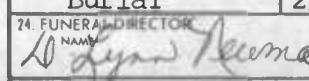
044458 FEB 19

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
FOR STATE REGISTRAR			REG. NO. 05157													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a DATE KNOWN OF DEATH ESTI- MATED					
Jesse		Willard			POWELL						2b. HOUR 1215AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD				
Male		White		Apr. 27, 1910		76 yrs.						2d. HOUR 11:45AM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett								
Virginia		USA														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route #3, Box 132-L						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Oakland								Engineer		Railroad						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21550						
Md.		Garrett		Oakland				Route #3, Box 132-L								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
Ermett		-----		Powell		Elizabeth		-----		Wright						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS												
Yes		1926		705-10-7073		Mrs. Ethel A. Powell, See #13 above										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART 1 DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years																
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																
(b) <u>Arteriosclerosis, generalized</u>																
DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, before an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER										DATE SIGNED 2-1-1987				
EXAMINER'S NAME (TYPE OR PRINT)		James E. Feaster, Jr., M.D., 107 S. 2nd. ST., Oakland, Maryland														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
burial		2/4/87		Fairview Cemetery		Oakland		Garrett		Maryland						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Bradley A. Stewart		Oakland, Maryland 21550		FEB 13 1987		Julia Feaster-Randall										
BP																
DHMH - 17 (VR A15 ME (5))																

100-30181834

046535

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05140 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR						
Cora			Adel			<input checked="" type="checkbox"/> 2 23 19 87			23 19 87			1045						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD						
Female		White		9/24/1896		90 yrs.		MONTHS		DAYS HOURS MIN		2 24 19 87						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA										<input checked="" type="checkbox"/> Garrett		Garrett				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Accident			Route 2, Box 94									Homemaker			Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			MD						
Maryland		Garrett		Accident		<input checked="" type="checkbox"/>			Route 2, Box 94			21520						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
John Wesley Schroyer			Amanda												Sweitzer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.					17. INFORMANT				ADDRESS					
				215-36-9816					Erma Jean Broadwater				Rt. 2, Box 94 Accident, MD 21520					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>												Years						
DUE TO, OR AS A CONSEQUENCE OF																		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																		
{ (b) <u>Arteriosclerotic cardio-vascular disease</u> "																		
DUE TO, OR AS A CONSEQUENCE OF																		
(c) _____																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED		2-24-87
EXAMINER'S NAME (TYPE OR PRINT)			James H. Feaster, Jr., M. D. 104 S. 2nd. St., Oakland, Md.										ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2/26/87			23c. NAME OF CEMETERY OR CEMINATORY St. Paul's Cemetery			23d. LOCATION CITY OR TOWN Accident			COUNTY Garrett		STATE MD				
24. FUNERAL DIRECTOR NAME 			ADDRESS Grantsville, Maryland			25a. DATE REC'D. BY REGISTRAR FEB 27 1987			25b. REGISTRAR'S SIGNATURE 									
07/84 25M		BP		DHMH - 17 (VR A15 ME (5))														

3

1881 1887

045230 FEB 26 1987  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low

referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 05141

1. DECEASED NAME (TYPE OR PRINT) Joshua Arthur RODEHEAVER			2a. DATE OF DEATH MONTH DAY YEAR February 21, 1987	2b. HOUR 11:55am
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 3, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Deer Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Rt. 3 21550
14. FATHER'S NAME FIRST William		MIDDLE Francis	LAST Rodeheaver	15. MOTHER'S MAIDEN NAME FIRST Sarah
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I	17. INFORMANT Mrs. Mary Rodeheaver - Mt. Lake Park, Md.	ADDRESS 202 'H' Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Arrhythmias</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Dehydration      Severe Rheumatoid Arthritis				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) (did not) view the body after death.				
22b. SIGNATURE Roger Lewis, M.D.				
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Lewis, M.D.				
22e. ADDRESS Terra Alta, W. Va.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/87	23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.	23d. LOCATION CITY OR TOWN Oakland
24. FUNERAL DIRECTOR NAME Durst Funeral Home - Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR FEB 25 1987	25b. REGISTRAR'S SIGNATURE Roger Lewis	
DHMH - 16 60M 7/84 (VRA 15, 4)				



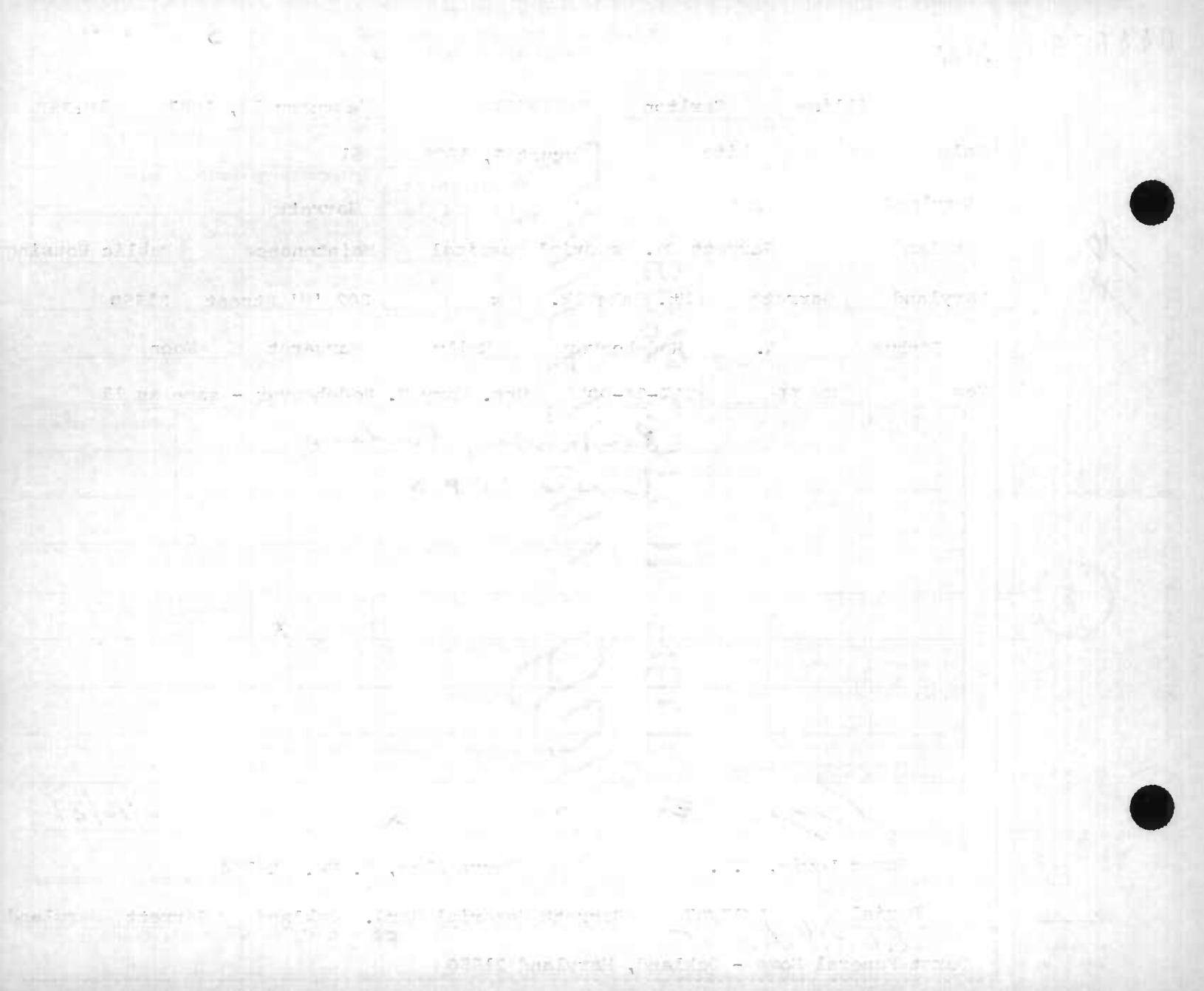
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Please remove carbon copies. Pages 1 and 2 should be used within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows other injury, or other traumatic event, the medical examiner should be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					05142			
					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William Carlton RODEHEAVER			February 14, 1987		10:35PM			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White	August 3, 1925		61		YRS	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		USA			Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett Co. Memorial Hospital			Maintenance		Public Housing	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland	Garrett	Mt. Lake Pk.			202 'H' Street		21550	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Joshua A. Rodeheaver			Emily Margaret Moon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes WW II			227-34-0029			Mrs. Mary M. Rodeheaver - same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe COPD.</i>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Roger Lewis, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Lewis, M.D.		22e. ADDRESS Terra Alta, W. Va. 26764						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/17/87		23c. NAME OF CEMETERY OR CREMATORIAL Garrett Memorial Gard		23d. LOCATION CITY OR TOWN Oakland		COUNTY STATE Garrett, Maryland
24. FUNERAL DIRECTOR NAME <i>Robert M. Durst</i>		ADDRESS Durst Funeral Home - Oakland, Maryland 21550		25a. MARRIED <input type="checkbox"/> REGISTERED <input checked="" type="checkbox"/> REGISTRAR <i>Robert M. Durst</i>		25b. REGISTRAR'S SIGNATURE <i>Robert M. Durst</i>		
BP _____								
DHMH - 16 60M 7/84 (VRA 15, 4)								





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove certificate from this page and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and examined immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										05144		
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			JUN. 30, 1987				2b. HOUR 8:45 PM		
Garold Walter Stemple			S. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX Male			4. RACE White			June 2, 1919				67 YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY WV.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.		
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor				12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE WV.			13b. COUNTY Preston		13c. CITY OR TOWN Aurora		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural 99999			
14. FATHER'S NAME FIRST Harry			MIDDLE B.			15. MOTHER'S MAIDEN NAME FIRST Ethel			LAST P. Tanner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 235-20-8937			17. INFORMANT Frances Stemple Rt. 1 Box 176			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			chronic obstructive pulmonary disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b)									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: coughing, arrhythmia, retroperitoneal fibrosis, aortic aneurysm												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/19/85 to 11/30/1987, that (I) (we) last saw the deceased alive on 11/30/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Margaret Kaiser			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 311 N 4th Suite 3 Oakland WV									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 3, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Stemple Ridge			23d. LOCATION CITY OR TOWN Aurora			
24. FUNERAL DIRECTOR NAME Lester R. Hinkle			ADDRESS Box 186 Davis, WV.			25. DATE REC'D. BY REGISTRAR MAR 03 1987			26. REGISTRAR'S SIGNATURE Lester R. Hinkle			
DHMH - 16 60M 7/84 (VRA 15, 4)												

MasterCard 08 30 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troune paper. Then please remove carbon paper. Pages 2 &amp; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, either traumatic or

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05143	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Alvin	MIDDLE Zealous	LAST STRAWSER	2a. DATE OF DEATH MONTH February 2, 1987			DAY YEAR	2b. HOUR 615 A.M.	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH Oct. 14, 1907			DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #1 21550			
14. FATHER'S NAME FIRST Henry			MIDDLE David		LAST Strawser	15. MOTHER'S MAIDEN NAME FIRST Ora			MIDDLE Nancy	LAST Gibson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-22-6843			17. INFORMANT Mrs. Oma K. Athey, Oakland, Md. 21550			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			cardiopulmonary arrest								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular accident						Months		
			DUE TO, OR AS A CONSEQUENCE OF (c) aspiration pneumonia						Weeks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic cardiovascular disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) saw the deceased alive on 1/15/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (we) attended the deceased from 1/15/87 to 1/15/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED 2/2/87	
22b. SIGNATURE Donald R. Richter			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 311 North Fourth St., Oakland, Md. 21550								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 2/5/87			23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.			23d. LOCATION CITY OR TOWN Oakland, Garrett, Maryland		
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR FEB 13 1987			25b. REGISTRAR'S SIGNATURE Julia Scidmore-Lambert		

1000 81 837

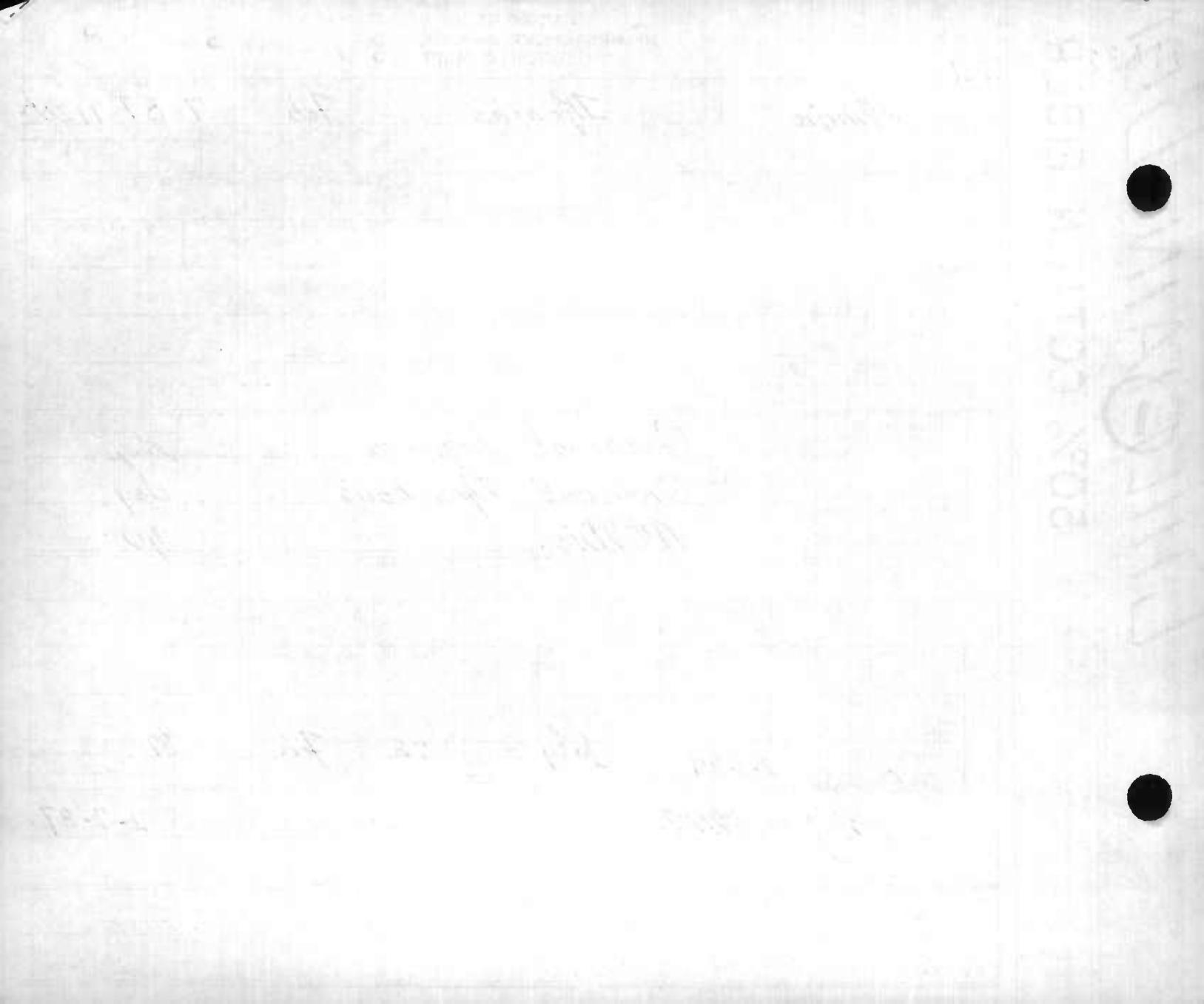
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

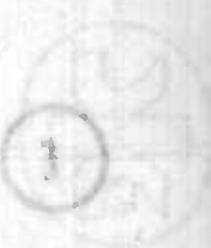
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (or used as the burial permit). Then please remove carbon deposit (page 1 and 2) could be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												05140	
1. DECEASED NAME (TYPE OR PRINT)				2. DATE OF DEATH				REG. NO.					
Minnie Florence Thomas				Feb 7 87									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/21/1890		6. AGE (IN YEARS LAST BIRTHDAY) 97		7. UNDER 1 YEAR MONTHS DAYS		8. HOUR HOURS MIN.			
9. BIRTHPLACE COUNTRY Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Garrett, MD							
13. CITY OR TOWN OF DEATH Oakland		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Cuppett-Weeks Nursing Home		15. USUAL OCCUPATION Homemaker		16. KIND OF BUSINESS OR INDUSTRY Own Home							
17. RESIDENCE IF IN HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION 18. STATE Maryland		18. COUNTY Garrett		19. CITY OR TOWN Friendsville		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. STREET ADDRESS / ZIP CODE Water Street, 21531					
22. FATHER'S NAME James		23. MOTHER'S NAME Savage		24. MOTHER'S MAIDEN NAME Fannie		25. ADDRESS P.O. Box 452, Redwd Dr.							
26. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN No		27. SOCIAL SECURITY NO. 212-54-8746		28. INFORMANT Mrs. Violet Schroyer State Line, PA 17263		29. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH							
30. CAUSE OF DEATH (Enter only one cause per line for Part I, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z, 1aa, 1ab, 1ac, 1ad, 1ae, 1af, 1ag, 1ah, 1ai, 1aj, 1ak, 1al, 1am, 1an, 1ao, 1ap, 1aq, 1ar, 1as, 1at, 1au, 1av, 1aw, 1ax, 1ay, 1az, 1aa1, 1ab1, 1ac1, 1ad1, 1ae1, 1af1, 1ag1, 1ah1, 1ai1, 1aj1, 1ak1, 1al1, 1am1, 1an1, 1ao1, 1ap1, 1aq1, 1ar1, 1as1, 1at1, 1au1, 1av1, 1aw1, 1ax1, 1ay1, 1az1, 1aa2, 1ab2, 1ac2, 1ad2, 1ae2, 1af2, 1ag2, 1ah2, 1ai2, 1aj2, 1ak2, 1al2, 1am2, 1an2, 1ao2, 1ap2, 1aq2, 1ar2, 1as2, 1at2, 1au2, 1av2, 1aw2, 1ax2, 1ay2, 1az2, 1aa3, 1ab3, 1ac3, 1ad3, 1ae3, 1af3, 1ag3, 1ah3, 1ai3, 1aj3, 1ak3, 1al3, 1am3, 1an3, 1ao3, 1ap3, 1aq3, 1ar3, 1as3, 1at3, 1au3, 1av3, 1aw3, 1ax3, 1ay3, 1az3, 1aa4, 1ab4, 1ac4, 1ad4, 1ae4, 1af4, 1ag4, 1ah4, 1ai4, 1aj4, 1ak4, 1al4, 1am4, 1an4, 1ao4, 1ap4, 1aq4, 1ar4, 1as4, 1at4, 1au4, 1av4, 1aw4, 1ax4, 1ay4, 1az4, 1aa5, 1ab5, 1ac5, 1ad5, 1ae5, 1af5, 1ag5, 1ah5, 1ai5, 1aj5, 1ak5, 1al5, 1am5, 1an5, 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1ae72, 1af72,													







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